W. Randy Weber D.D.S.

ADOLESCENT REGISTRATION & HEALTH HISTORY QUESTIONNAIRE

Patient's Name _____ Date _____

Home Address _____ City _____ State _____ Zip _____

Home phone number _____

Birthdate _____ **YOUR AGE** _____

Any Brothers and/or Sisters? _____ Age(s) _____

Father's Name _____	Mother's Name _____
Address _____	Address _____
Home Phone _____	Home Phone _____
Employer _____	Employer _____
Work Phone _____	Work Phone _____
SSN _____	SSN _____
Birthdate _____	Birthdate _____

Do you have Dental Insurance? _____

Name of Insurance Company? _____

DENTAL HEALTH HISTORY

1. Reason for this appointment? _____
2. Date of last dental treatment? _____
3. What was the last appointment for? _____
4. Do you have any pain in your teeth because of heat, cold, sweets or chewing? _____
5. Do your gums bleed, or feel tender, either when chewing or brushing or at any other time? _____
6. Are you aware you can have gum disease and bone destruction without pain? _____
7. Are you aware of clenching your teeth? _____
8. Do you have headaches, neck tension, tired jaws, or ear problems? _____
9. Do you feel you have mouth odor? _____
10. Have you been shown how to do proper bacterial reduction for your mouth by:

    Brushing? _____ Flossing? _____ Do you floss? _____ Use a water pic? _____

11. If you could, what would you change about your smile? _____
12. Would you be interested in easily whitening your teeth? _____
13. What would you like your teeth to be like in 20 years? _____

    Natural teeth _____ Healthy teeth _____ Dentures _____

14. How often do you have your teeth and gums cleaned? Every _____ months.

Turn Over....

MEDICAL HEALTH HISTORY...

Name _____ Age _____

General Health (Please Check): _____ Excellent _____ Good _____ Fair _____ Poor

1. Are you having pain or discomfort at this time? _____ YES NO
2. Do you feel very nervous about having dentistry treatment? _____ YES NO
3. Have you been a patient in the hospital during the past two years? What for? _____ YES NO
4. Have you been under the care of a medical doctor during the past two years? What for? _____ YES NO
5. Are you taking any medicine now? What? _____ YES NO

_____

6. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? _____ YES NO
7. Have you ever had any excessive bleeding requiring special treatment? _____ YES NO
8. Circle any of the following which you have had or have at present:

Allergies or Hives	Drug Addiction	Nervousness
Anemia	Epilepsy or Seizures	Pain in Jaw Joints
Arthritis	Fainting or Dizzy Spells	Psychiatric Treatment
Artificial Heart Valve	Hay Fever	Rheumatic Fever
Artificial Joint	Heart Murmur	Scarlet Fever
Asthma	Heart Surgery	Sickle Cell Disease
AIDS	Hearing Problems	Sinus Trouble
Blood Transfusion	Hemophilia	Stroke
Bruise Easily	Hepatitis A (infectious)	Thyroid Disease
Chemotherapy (Cancer, Leukemia)	Hepatitis B (serum)	Tuberculosis (TB)
Cold Sores	High Blood Pressure	Ulcers
Congenital Heart Lesions	Kidney Trouble	X-Ray or Cobalt Treatment
Cortisone Medicine	Latex Allergy	Venereal Disease
Diabetes	Liver Disease	Yellow Jaundice

Name of Physician: _____

9. Are you on a special diet? _____ YES NO
10. Has your medical doctor ever said you have a cancer or tumor? _____ YES NO
11. Do you have any disease, condition, or problem not listed? _____ YES NO
12. Do you smoke? _____ YES NO
13. Do you use other tobacco products? _____ YES NO
14. WOMEN: Are you pregnant now? _____ YES NO

    Are you taking birth control pills? _____ YES NO

    Do you anticipate becoming pregnant? _____ YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Signature of Parent or Guardian _____

FINANCIAL POLICIES...

Please review our financial arrangement information sheet. Our office wants all our patients to be able to comfortably afford dental care. Emergency treatment fees are due at the time of service.

Signature of Parent or Guardian _____ Date _____